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OPERATION RESTORE TRUST



January 14, 1997

Mr. Curtis Lord, VP Program Safeguards
Blue Cross/Blue Shield of Florida
532 Riverside Avenue
PO Box 2078
Jacksonville, FL 32231-0048

Dear Mr. Lord:

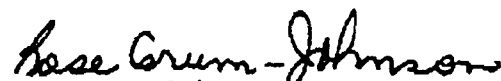
The enclosed report provides the results of the Operation Restore Trust (Wedge Project) review of the Jerome Feldman, Community Mental Health Center (Provider #10-4734) located in Orlando, Florida. The objectives of this review were two-fold: first, to evaluate whether the provider met the certification requirements for a CMHC to provide Partial Hospitalization services in accordance with § 1861 ff of the Social Security Act and § 1916 (c)(4) of the Public Health Service Act; and, secondly, to evaluate the payments made to the provider to ensure they were appropriate.

A sample of 20 beneficiaries was reviewed for the period January 1996 through December 1996. Our findings will require corrective actions by the Fiscal Intermediary, HCFA, and the OIG.

Please prepare and submit to the HCFA Miami ORT office, an action plan to implement recommendations made in this report that pertain to your organization.

If there are any questions regarding this report, please call Dewey Price at 305-536-6772 or Sheila Kanaly at 305-536-6588.

Sincerely,


Rose Crum-Johnson
HCFA Region IV Administrator


Charles Curtis
Region Inspector General-Audit

cc: Angela Bryce-Smith, HCFA CO
Mario Pelaez, OIG-OA
George Jacobs, HCFA Region IV
Dale Kendrick, HCFA Region IV
Eugene Grasser, HCFA Region IV
Barbara Bisno, AUSA

JEROME FELDMAN COMMUNITY MENTAL HEALTH CENTER
Provider 10-4734

I. INTRODUCTION

The Secretary of the Department of Health and Human Services and the President initiated Project Operation Restore Trust (ORT), an innovative, collaborative project designed to address growing concerns over rising health care costs. A review of departmental records indicated that over the last 10 years, many segments of the health care industry have experienced a surge in health care fraud and that the States of Texas, California, Illinois, New York and Florida receive annually over 40 percent of all Medicare and Medicaid funds. As a result, these States were selected to participate in the ORT 23-month pilot project.

Within the Department of Health and Human Services, ORT has been a joint effort by HCFA, the OIG, and the Administration on Aging. These components are focusing attention on program vulnerabilities identified through investigations and audits. In 1997, HCFA, its State agencies and contractors, and the OIG carried out various projects (commonly referred to as wedge projects). In the State of Florida, one of these projects involved onsite reviews of community mental health centers (CMHCs). Through analysis of HCFA Customer Information System (HCIS) billing data, and review of complaints, ten CMHCs were selected for onsite review.

These onsite reviews were conducted by an ORT team consisting of representatives from HCFA, the Medicare Blue Cross/Blue Shield contractor, the Florida Agency for Health Care Administration, and the Office of Inspector General (OIG)- Office of Audit Services, Miami.

This report provides the results of the combined review of the Jerome Feldman Community Mental Health Center Partial Hospitalization Program (PHP) conducted on June 16, 1997 through June 20, 1997.

II. EXECUTIVE SUMMARY

The objectives of the review were to:

- 1) determine whether the provider met the certification criteria for a Community Mental Health Center;
- 2) determine whether the 20 sample Medicare beneficiaries met the eligibility requirements for the Partial Hospitalization Program (PHP) benefit;
- 3) determine whether the Medicare coverage and reimbursement criteria were met for PHP services claimed by Jerome Feldman from 1/1/96 through 12/31/96 on behalf of

the 20 sample Medicare beneficiaries; and,

4) determine whether the costs claimed on Jerome Feldman's 1996 cost report were allowable, reasonable, and necessary.

The significant findings of our review were as follows.

1) The team determined that the facility did not meet certification requirements to operate as a CMHC under sections 1916(c)(4) of the Public Health Service Act and section 1861 of the Social Security Act. Specifically, the provider was not familiar with these requirements and was unable to substantiate provision of any of the five required core services. Therefore, it is recommended that this provider's number be voided and that all payments made to the provider since its effective date of participation in the Medicare program be recouped (this amount approximates \$2,554,314 as per the Medicare Part A Provider Summary Report).

2) The team's medical review of 16 of the 20 sample beneficiaries found that none were eligible for PHP benefits. The provider was unable to produce any medical records for 4 of the 20 sampled beneficiaries. In addition, the provider had established business relationships with several Assisted Living Facility (ALF'S) operators to enhance in the enrollment of ineligible patients.

3) The services provided to the sample 20 Medicare beneficiaries for whom Jerome Feldman submitted claims for PHP services for the period of January 1, 1996 through December 31, 1996 represented a net reimbursement in the amount of \$474,431. The medical review conducted by the Fiscal Intermediary (FI) staff and HCFA concluded that all of the services claimed for 16 of 20 beneficiaries during the reviewed period did not meet the Medicare coverage and reimbursement criteria and that the content of the group sessions was social, recreational, and diversionary, rather than of a psychotherapeutic nature.

4) The provider was unable to produce complete or sufficient financial records or data for the 1996 cost report, hence an audit of this cost report could not be completed. We are instructing the FI to disallow all net reimbursement for CY 1996 (this amounts to \$992,232 paid to the CMHC as the net reimbursement for CY 1996.)

In addition, the review discovered evidence of inappropriate business transactions involving this provider, former employees and certain ALF operators. Nominees were used by the physician owner to set up additional providers that signed

management/consulting contracts with him; also, payments were made to ALF owners from whom patient referrals were received.

5) The physical plant housing the CMHC/PHP was an abandoned warehouse that had been previously condemned by the local county authorities. The building was in extreme disrepair and unsanitary and unsafe conditions were found, including a lack of running water, no fire safety equipment and no kitchen to prepare food existed. After local health and fire safety officials were informed by HCFA review staff of these conditions, the building was condemned and action taken by the Fire Marshall to immediately remove the patients. HCFA subsequently terminated the provider agreement based on a cessation of business [42 CFR 489.52(b)(3)]. HCFA also directed the FI(BlueCross/Blue Shield of Florida) to immediately suspend all payments to the provider effective June 18, 1996.

The results of this review were referred to the OIG Office of Investigations and to the United States Attorneys Office for the Middle district of Florida.

III. BACKGROUND

Title XVIII of the Social Security Act (the Act) authorizes the Medicare program to provide medical benefits to individuals who are age 65 or over, and certain individuals under age 65 who are disabled or suffering from end-stage renal disease. Section 1835 of the Act established coverage of partial hospitalization services for Medicare beneficiaries. Section 1861(ff)(2) of the Act generally defines partial hospitalization services as those [mental health] services that are reasonable and necessary for the diagnosis or active treatment of the individual's condition and functional level and to prevent relapse or hospitalization, and furnished pursuant to such guidelines relating to frequency and duration of services as the Secretary will by regulation establish.

Section 4162 of Public Law 101-508 (OBRA 1990) amended Section 1861 of the Act to include CMHCs as entities that are authorized to provide partial hospitalization services under Medicare. Section 1916(c)(4) of the PHS Act lists the services that must be provided by a CMHC.

A Medicare-certified CMHC can either provide PHP services directly, or under arrangement with other providers to render the services required of a CMHC by the Public Health Service Act. The services claimed by the provider were provided by salaried employees, most of whom did not possess the required licenses and certifications.

HCFA's definition of a CMHC is based on §1916(c)(4) of the Public Health Service (PHS) Act. The PHS definition of a CMHC is cross-referenced in section 1861(ff) of the Act. HCFA defines a CMHC as an entity that provides:

- ⇒ Outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically mentally ill, and residents of its mental health services area who have been discharged from inpatient treatment at a mental health facility;
- ⇒ 24-hour a day emergency care services;
- ⇒ Day treatment or other partial hospitalization services or psychosocial rehabilitation services;
- ⇒ Screening for patients being considered for admission to State mental health facilities to determine the appropriateness for such admission; and
- ⇒ Consultation and education services.

Section 1833(a)(2)(B) of the Act provides that CMHCs will be paid for PHP services on the basis of reasonable costs. During the year, a CMHC receives interim payments based on a percentage of its billed charges. These payments are intended to approximate the CMHC's reasonable costs. Upon receipt of the annual Medicare cost report, the FI makes a settlement payment based on the reasonable costs incurred.

In order for a Medicare patient to be eligible for a partial hospitalization program, a physician must certify (and recertify where such services are furnished over a period of time): (Section 1835(a)(2)(F) of the Act)

- 1) That the individual would require inpatient psychiatric care in the absence of such services. This certification may be made where the physician believes that the course of the patient's current episode of illness would result in psychiatric hospitalization if the partial hospitalization services are not substituted.
- 2) An individualized plan for furnishing such services has been established by a physician and is reviewed periodically by a physician, and
- 3) Such services are or were furnished while the individual is or was under the care of a physician.

A Medicare partial hospitalization program is an appropriate level of active treatment intervention for individuals who:

- ◆ Are likely to benefit from a coordinated program of services and require more than isolated sessions of outpatient treatment. Partial hospitalization is the level of intervention that falls between inpatient hospitalization and episodic treatment on the continuum of care for the mentally ill;
- ◆ Do Not require 24-hour care and have an adequate support system outside the hospital setting while not actively engaged in the program;
- ◆ Have a diagnosis that falls within the range of ICD-9 codes for mental illness (i.e. 290 through 319). However, the diagnosis in itself is not the sole determining factor for coverage, and
- ◆ Are not judged to be dangerous to self or others.

The Jerome Feldman CMHC is a for-profit corporation with its principal place of business in Orlando, Florida. Its effective date of participation in the Medicare program was December 14, 1994. The provider number was granted based on a self-attestation statement certifying the facility's compliance with the Federal requirements in Sec. 1861(ff)(3)(B) of the Public Health Service Act, and its conformance with the provisions concerning Medicare provider agreements. The provider was informed that the Medicare Provider Identification Number was for certification of the Orlando facility only, and that any satellite offices, branch offices, or multiple sites would have to be certified independently.

IV. SCOPE, AND METHODOLOGY

In order to determine if the provider met the certification requirements for a CMHC, Jerome Feldman staff were interviewed and requested to provide documentation (including medical records) demonstrating their provision of the five required core services of a CMHC under Section 1861(ff)(3)(b)(ii) of the Social Security Act.

During the review, applicable laws, regulations, and Medicare guidelines were used to determine whether the sample beneficiaries and the services claimed met the Medicare eligibility and reimbursement guidelines. The medical review was performed using the criteria set forth in Title 42 CFR 424.24 which provides that Medicare pays for partial hospitalization services only if a physician certifies the content of the plan of care. The plan must include the physician's diagnosis, the type, frequency, and duration of services to be administered, and the goals of the treatment plan. In addition, the patient must meet eligibility criteria to receive PHP services.

The medical review was conducted by staff from HCFA and the fiscal intermediary. The review process consisted of a review of all claims submitted by Jerome Feldman CMHC for the 20 sample beneficiaries between January 1st and December 31st, 1996. The sample used for this review was not based upon a statistically valid random sample, and therefore, the results would not be

extrapolated to the entire universe of the provider's claims.

The financial data, reports, and supporting documentation for fiscal year 1996 were requested to determine if costs claimed on the FY 1996 cost report were allowable, reasonable, and necessary.

The field work was conducted at the Jerome Feldman CMHC site in Orlando, Florida, at the Lake Mary Florida satellite location, at New Understandings in Holly Hill, Florida and at the residence of a former employee of the provider. The site visit began June 16, 1997, and concluded on June 20, 1997.

V. FINDINGS

1. *Certification*

In our review of Jerome Feldman CMHC, we met with and interviewed its owner who was asked to provide documentation substantiating the provision of the five required core services. The provider was unfamiliar with these requirements and was not able to provide any documented evidence to show compliance with the five core services. On December 10, 1994, the provider had applied for a Medicare provider number and signed an attestation form indicating compliance with Medicare requirements that allowed certification by HCFA as a CMHC. As a result of this misrepresentation, and based on the overpayments found in the medical review, HCFA directed the FI to suspend without notice all payments to the provider effective August 19, 1997.

The building which housed this provider was found by the reviewers to be an abandoned warehouse that had been previously condemned by the local county authorities. The building was in extreme disrepair and unsafe and unsanitary conditions were observed, including a lack of running water, no fire safety equipment and food preparation activities were observed that were unacceptable to the State Agency, FI and HCFA reviewers. The conditions were considered so deplorable, that after discussion with the ORT Team Leader, a decision was made to request the assistance of local Health and Fire Safety authorities. An inspection was subsequently performed by officials of Orange County, Florida, resulting in the building being condemned and all patients/staff being evacuated. HCFA subsequently terminated the provider agreement effective June 23, 1997, the date the provider ceased business.

2. *Patient Eligibility and Physician Certification*

At the initiation of the on-site review, the provider was unable to produce any of the 1996 medical records. The provider indicated that the records had been seized by representatives of the Florida Medicaid Fraud Bureau. Follow up with the Florida Attorney General's office revealed that none of the documentation taken had involved medical records for the 20 sampled beneficiaries. Later the provider supplied 16 of the 20 sampled records that had been located at another site. Four records

in the sample remained missing.

The medical review determined that payment for all of the services claimed by Jerome Feldman for the 20 beneficiaries should be denied because the beneficiaries did not meet the Medicare eligibility criteria for PHP services (see attached chart delineating the medical review results for the 20 beneficiaries in the sample). Specifically, the review determined that none of the beneficiaries required the intensive services of a partial hospitalization program. There were no physician certifications for PHP services in the 16 of 20 reviewed medical records. The documentation in these medical records did not show symptoms of severe psychiatric disorders which would have required inpatient hospitalization in lieu of PHP services.

3. Medical Necessity

The medical review also found the services to the 16 of 20 sampled beneficiaries were not reasonable and necessary and that the content of the groups presented was social, recreational and diversionary, rather than of a psycho-therapeutic nature. The documentation in the medical records for the 16 beneficiaries contained identical statements i.e., they were not individualized according to each patient's treatment, progress, and diagnosis. The same group sessions were recommended for all patients. As a result of the medical review, \$474,431 which is the amount of the net reimbursement to Jerome Feldman on the 20 sampled beneficiaries, is considered an overpayment.

In addition, none of the staff providing services were licensed or qualified to conduct group therapy. Interviews with former staff and current employees revealed that they had been trained by Dr. Feldman to document clinical notes using specific terms to "pass Medicare." Staff indicated that generic forms were used and that the physician rarely signed or reviewed the documentation.

4. Cost Issues

Medicare cost principles limit reimbursement to the costs that would be incurred by a reasonable, prudent and cost-conscious management. 42 CFR 413.9 provides that all payments to providers must be based on the "reasonable cost" of services covered under Title XVIII of the Act and related to the care of the Medicare beneficiaries. The regulations at 42 CFR 413.9 state in part that costs which are not necessary include costs which usually are not common or accepted occurrences in the field of the provider's activity. Since the provider was unable to produce sufficient financial data or costs reports for 1995 or 1996, no determination could be made regarding the allowability of charges.

Evidence was obtained that the provider established business relationships with ALF operators to assist in identifying and enrolling ineligible beneficiaries into the partial hospitalization program. Through interviews with three former employees, we obtained testimonial evidence indicating that family members of the ALF owners were included on the CMHC payroll and that those individuals did not perform any services for the facility. We were also informed that Jerome Feldman CMHC paid for the health insurance of an Assisted Living Facility (ALF) owner, and that many of these ALF's residents were attending the PHP at the Jerome Feldman CMHC. We were, however, unable

to verify these payroll and benefit expenses due to the insufficiency and inadequacy of the financial records.

Through interviews with three former employees and one current employee, we learned that Dr. Feldman approached three young female employees and offered each one a similar business proposal. He told them that Medicare would not allow him to own or operate any other CMHC's under his provider number and that he was worried that his applications for additional provider numbers would be denied. He told them that they could earn a great deal of money if they operated their own PHP's. Dr. Feldman offered to provide all of the necessary financial support to open the facilities as long as the women applied for the provider numbers themselves. All three women agreed to the offer, but only one facility, A New Understanding, actually had received a Medicare provider number (at the time of our review) and was providing services. (The other two pending applications were withdrawn after our onsite review).

According to testimonial evidence concerning A New Understanding in Holly Hill, Florida, Dr. Feldman provided the patients and certified their medical necessity for PHP services in return for a "management contract" equal to 50 percent of A New Understanding's gross Medicare charges. Until the facility received its provider number from Medicare in April 1997 (retroactive to April 1996), all administrative costs were assumed by Dr. Feldman. For approximately one year, Dr. Feldman transported his Orlando patients 60 miles to this facility and certified their medical necessity for PHP services. We have verified that he has received at least \$64,000 from A New Understanding.

Evidence was obtained that Dr. Feldman leased office space and operated another facility in Lake Mary, Florida, called Overbridge, which did not have its own provider number. Originally, this facility was opened under a nominee ownership arrangement with a former employee, but a provider number was never applied for. We verified that Dr. Feldman is transporting his Orlando patients to the facility, and billing the services to Medicare as if they were provided at the Orlando facility. We also obtained testimonial evidence that the operational costs for Overbridge are included in the Cost Report for the Orlando facility. This cannot be verified due to the insufficiency of the financial records.

In June 1997, Dr. Feldman entered into a contractual arrangement with ARTS of Brevard, a CMHC in Melbourne, Florida to provide medical consultation services at a rate of \$200/hour. In interviews with ALF owners and beneficiaries, we reviewed the Explanation of Medicare Benefits that was issued to several beneficiaries. We noted that these patients were seen not only at the Jerome Feldman CMHC, but also were transported to ARTs of Brevard CMHC. After the closure of the Jerome Feldman CMHC, we noted that the beneficiaries in our sample were being transported to Arts OfBrevard. We obtained evidence that Dr. Feldman has been transporting his Orlando patients to this facility, in what we believe to be a "brokering arrangement"; ARTS of Brevard may bill Medicare for PHP services provided to Dr. Feldman's patients, and Dr. Feldman bills Medicare Part B for his consultation services in addition to his \$200/hour consulting fee.

During the course of our review we discovered that Dr. Feldman billed Medicare Part B for these same patients who were receiving PHP benefits. In that these patients were never eligible for the PHP benefit, the billings to Part B should have been denied. Given this information, the huge consulting contracts with other CMHCs such as New Understandings and Arts of Brevard, and deliberate attempts to circumvent Medicare regulations, HCFA-Miami directed the carrier to suspend all Part B payments to the physician owner.

6. Law Enforcement Action

On the last day of this review, the team concluded that the findings from this review warranted immediate action and referral to law enforcement. The team met with the United States Attorney's Office for the Middle District of Florida and turned over a summary of our findings to him. In addition to the evidence collected by the team, the team requested that the U.S. Attorney's Office obtain a temporary restraining order (TRO) in order to freeze the assets of this agency. The procedure in the Southern District of Florida has been to obtain a TRO at the same time that suspension actions are undertaken. However, the U. S. Attorney's office in Orlando did not have a similar process in place and thus forwarded our request to their headquarters in Washington, D.C. The team was also concerned about the nature and scope of the previous inquiry by Medicaid Program Integrity Staff and felt there was a need for coordination as to both cases. The team was informed that there was a joint case in progress against Jerome Feldman CMHC and Jerome Feldman individually related both to Medicare and Medicaid billings. The information that the team had obtained was given to the U.S. Attorney assigned to the case who indicated he would coordinate matters with the OIG agent already assigned to the case.

Recommendations

Based upon HCFA's determination that the provider did not meet certification requirements to operate as a CMHC under the guidelines set forth in the Public Health Services Act, the Fiscal Intermediary should recover all payments made to this provider (from the provider's effective date of participation in the Medicare program); and should maintain the suspension of payments until advised otherwise by HCFA;

The AUSA for the Middle District of Fla. , OIG-Office of Investigations, and other involved investigative agencies, should consider further actions against this provider, including evaluation for civil/criminal action against the responsible individuals.

JEROME FELDMAN CMHC (PROVIDER NO. 10-4734)
Review Performed for the year 1996.*

Record No.	Bene Hic No.	Results of Medical Review	Review Results	Amount Paid	Amount Denied
1	351-14-9629CI	1. No medical records available for 1996.	Deny all Services.	\$37,310	\$37,310
2	212-22-1395A	1. Partial hospitalization services and program do not qualify for the PHP benefit under § 1861 ff(2). 2. Patient did not meet eligibility criteria under § 1835 (a)(2)(F). 3. Documentation incomplete to support necessity for services.	Deny all Services.	\$35,260	\$35,260
3	265-25-8649A	1. Partial hospitalization services and program do not qualify for the PHP benefit under § 1861 ff(2). 2. Patient did not meet eligibility criteria under § 1835 (a)(2)(F). 3. Services not reasonable or necessary under § 1862 (a)(1)(A).	Deny all Services.	\$32,190	\$32,190
4	267-32-0712A	1. Partial hospitalization services and program do not qualify for the PHP benefit under § 1861 ff(2). 2. Patient did not meet eligibility criteria under § 1835 (a)(2)(F). 3. Documentation incomplete to support necessity for services.	Deny all Services.	\$30,580	\$30,580
5	267-44-5664CI	1. Partial hospitalization services and program do not qualify for the PHP benefit under § 1861 ff(2). 2. Patient did not meet eligibility criteria under § 1835 (a)(2)(F). 3. Services not reasonable or necessary under § 1862 (a)(1)(A).	Deny all Services.	\$29,270	\$29,270
6	263-91-2516A	1. Partial hospitalization services and program do not qualify for the PHP benefit under § 1861 ff(2). 2. Patient did not meet eligibility criteria under § 1835 (a)(2)(F). 3. Documentation incomplete to support necessity for services.	Deny all Services.	\$27,840	\$27,840

Record No.	Bene Hic No.	Results of Medical Review	Review Results	Amount Paid	Amount Denied
7	204-48-1081A	1. Partial hospitalization services and program do not qualify for the PHP benefit under § 1861 ff(2). 2. Patient did not meet eligibility criteria under § 1835 (a)(2)(F). 3. Services not reasonable or necessary under § 1862 (a)(1)(A).	Deny all Services.	\$27,780	\$27,780
8	275-58-9886A	1. Partial hospitalization services and program do not qualify for the PHP benefit under § 1861 ff(2). 2. Patient did not meet eligibility criteria under § 1835 (a)(2)(F). 3. Services not reasonable or necessary under § 1862 (a)(1)(A).	Deny all Services.	\$27,360	\$27,360
9	223-82-5116A	1. Partial hospitalization services and program do not qualify for the PHP benefit under § 1861 ff(2). 2. Patient did not meet eligibility criteria under § 1835 (a)(2)(F). 3. Documentation incomplete to support necessity for services.	Deny all Services.	\$26,420	\$26,420
10	471-16-1093D6	No medical records available.	Deny all Services.	\$25,786.94	\$25,786.94
11	266-90-7739A	1. Partial hospitalization services and program do not qualify for the PHP benefit under § 1861 ff(2). 2. Patient did not meet eligibility criteria under § 1835 (a)(2)(F). 3. Services not reasonable or necessary under § 1862 (a)(1)(A).	Deny all Services.	\$22,500	\$22,500
12	261-30-4625W	1. Partial hospitalization services and program do not qualify for the PHP benefit under § 1861 ff(2). 2. Patient did not meet eligibility criteria under § 1835 (a)(2)(F). 3. Documentation incomplete to support necessity for services.	Deny all Services.	\$20,520	\$20,520

Record No.	Bene Hic No.	Results of Medical Review	Review Results	Amount Paid	Amount Denied
13	261-58-8673C2	1. Partial hospitalization services and program do not qualify for the PHP benefit under § 1861 ff(2). 2. Patient did not meet eligibility criteria under § 1835 (a)(2)(f). 3. Documentation incomplete to support necessity for services.	Deny all Services.	\$20,370	\$20,370
14	099-36-1321A	1. Partial hospitalization services and program do not qualify for the PHP benefit under § 1861 ff(2). 2. Patient did not meet eligibility criteria under § 1835 (a)(2)(f). 3. Services not reasonable or necessary under § 1862 (a)(1)(A).	Deny all Services.	\$19,120	\$19,120
15	059-44-6897A	1. Partial hospitalization services and program do not qualify for the PHP benefit under § 1861 ff(2). 2. Patient did not meet eligibility criteria under § 1835 (a)(2)(f). 3. Documentation incomplete to support necessity for services.	Deny all Services.	\$17,260	\$17,260
16	180-14-9632C1	1. Partial hospitalization services and program do not qualify for the PHP benefit under § 1861 ff(2). 2. Patient did not meet eligibility criteria under § 1835 (a)(2)(f). 3. Services not reasonable or necessary under § 1862 (a)(1)(A).	Deny all Services.	\$16,174	\$16,174
17	027-14-7454C1	1. Partial hospitalization services and program do not qualify for the PHP benefit under § 1861 ff(2). 2. Patient did not meet eligibility criteria under § 1835 (a)(2)(f). 3. Services not reasonable or necessary under § 1862 (a)(1)(A).	Deny all Services.	\$16,000	\$16,000
18	123-20-0460C3	No medical records available for 1996.	Deny all Services.	\$15,770	\$15,770
19	074-54-2238A	No medical records available for 1996.	Deny all Services.	\$13820	\$13820
20	266-80-2647A	No medical records available for 1996.	Deny all Services.	\$13,100	\$13,100

Total Amount Paid/Denied		\$474,430.94	\$474,430.94
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***Provider was shut down by the County Fire Department in July 1997. HCFA revoked the provider number on the basis of cessation of business.